U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 21 March 2007

Case No.: **2004-BLA-05323**

In the Matter of:

T. G.,
Claimant,
v.

BLUE MOUNTAIN ENERGY,
Employer
and

OLD REPUBLIC INSURANCE COMPANY, INC.
Carrier,
and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest.

Appearances: Thomas E. Johnson, Esq.
For the Claimant

Richard H. Risse, Esq.
For the Employer

Before: RICHARD K. MALAMPHY
Administrative Law Judge

DECISION AND ORDER - DENYING BENEFITS

This case arises from a claim for federal benefits under the "Black Lung Benefits Act," Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, 30 U.S.C. § 901 et seq. ("ACT"), and applicable regulations, mainly 20 C.F.R. Parts 410, 718 and 727 ("Regulations").

The Act and Regulations provide compensation and other benefits to: (1) living coal miners who are totally disabled due to pneumoconiosis and their dependents; (2) surviving dependents of coal miners whose death was due to pneumoconiosis; and (3) surviving dependents of coal miners who were totally disabled due to pneumoconiosis at the time of their death (for claims filed prior to January 1, 1982). See also Sections 718.306 and 727.204 for

entitlement presumptions in certain death claims filed before April 30, 1982, where the miner was partially disabled at death. Other benefits include necessary medical and hospitalization costs required for the treatment of pneumoconiosis. The Act and Regulations define pneumoconiosis ("black lung disease" or "CWP") as a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. See § 718.201.

A formal hearing was held in Grand Junction, Colorado on May 18, 2006, at which all parties were afforded a full opportunity to present evidence and argument, as provided in the Act and the Regulations issued thereunder, found in Title 20, Code of Federal Regulations, Parts 725 and 718.

ISSUES

The contested issues are:

1. Whether the Claimant has pneumoconiosis;

2. Whether the Claimant's pneumoconiosis arose out of his coal mine employment;

3. Whether the Claimant is totally disabled; and

4. Whether the Claimant's total disability is due to pneumoconiosis. (DX 31)[1]

PRELIMINARY MATTERS

The District Director, in a Proposed Decision and Order dated February 6, 2003, concluded that the Miner was totally disabled due to coal workers' pneumoconiosis. (DX 29) The putative responsible operator rejected the Proposed Decision and Order and requested a formal hearing before an administrative law judge. (DX 30)

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Coal Miner

The Claimant was a coal miner within the meaning of § 402(d) of the Act and § 725.202 of the Regulations for at least thirty years. (See Stipulation of Parties at TR 16)

[1] The following abbreviations have been used as citations to the record:

ALJX	-	Administrative Law Judge's Exhibits;
CX	-	Claimant's Exhibits;
EX	-	Employer's Exhibits;
DX	-	Director's Exhibits; and
TR	-	Transcript of Hearing.

Date of Filing

The Claimant filed his claim for benefits under the Act on June 15, 2001. (DX 2). None of the Act's filing time limitations are applicable, thus the claim was timely filed.

Responsible Operator

Blue Mountain Energy is the last Employer for whom the Claimant worked a cumulative period of at least one year and is the properly designated responsible coal mine operator in this case under Subpart F of Part 725 of the Regulations. (See Stipulation at TR 16).

Dependent

The Claimant has one dependent for purposes of augmentation of benefits under the Act, his wife. (DX 2, TR 22).

Background and Employment History

The Claimant

At the hearing, the Claimant testified that he retired on January 7, 2004. (TR 22) He stated that by the time he retired he was less capable of performing his job. (TR 44) He was unable to "keep up" because of fatigue. (TR 44)

At the time of his retirement, the Claimant was employed as an acting general foreman. (TR 41-43) Prior to working as an acting general foreman, he was a shift foreman for approximately thirteen years. (TR 30, 41) Before becoming a shift foreman, he held a variety of other mining jobs. (TR 22-30)

As a shift foreman, the Claimant was required to supervise numerous workers and complete some paperwork. (TR 30, 51) However, the job also required rigorous physical activity. (TR 34-41) The Claimant often helped stack timbers or concrete blocks to reinforce the mine's roof, using materials that weighed between 30 and 150 pounds. (TR 34-35) He was also required to carry bags of rock dust weighing fifty pounds and shovel coal that fell off of the belt lines. (TR 37-38) Further, on an average day he walked between ten and fifteen miles. (TR 40)

The Claimant admitted that after becoming the acting general foreman, his workload probably lessened. (TR 52) He performed the same physically demanding tasks as the acting general foreman that he did as a shift foreman. (TR 53) He just did not always have to perform the tasks as often. (TR 53)

The dust level in this mine, a mine which produced as much as two million tons of coal in one year, and as much as 2,500 tons of coal in one hour, was significant. (TR 31-34) The Claimant stated that, when the miners were cutting the entries or when the machines were digging into the coal, a substantial amount of dust was being generated. (TR 32) Further, in

some areas, where used air was brought out of the mine, dust from the active production areas was also being expelled. (TR 33-34) At these areas, where the Claimant often worked, the dust level was very high. (TR 34) The Claimant stated that "[c]oal mining is dusty business. If you're not eating coal dust, you're blowing rock dust." (TR 34)

The Claimant acknowledged that he smoked cigarettes from 1962 to 1996 at a rate of about one pack per day. (TR 47) He occasionally smoked a pipe, although he did not inhale. (TR 48-49, 60)

The Claimant now experiences significant shortness of breath. (TR 46). He has difficulty carrying things or doing other manual labor, such as digging holes in his yard. (TR 46) When performing such tasks, he has to sit down and rest. (TR 46) He stated, "I just don't have the stamina. Seems like I wear out easy." (TR 46)

Dr. Lawrence Repsher

Dr. Lawrence Repsher testified at the hearing that he is an internist and that he specializes in pulmonary diseases. (TR 62) He is also a B-Reader. (TR 63) Further, he is certified as an examiner for the Colorado Workers' Compensation Board. (TR 63)

Dr. Repsher stated that he examined the Claimant in September of 2002. (TR 63) During that examination, the Claimant underwent a chest x-ray. (TR 64) Dr. Repsher found no evidence of pneumoconiosis on the x-ray. (TR 64) He did determine that the Claimant had some intrinsic lung disease, with mild obstruction, and probably some emphysema, but did not believe that any of these conditions were caused by the Claimant's coal mine work, or that any of these conditions would prevent the Claimant from returning to his prior coal mine employment. (TR 96). Dr. Repsher stated that the Claimant's mild obstructive breathing impairment was due solely to cigarette smoke. (TR 101)

Dr. Repsher noted that he reviewed a report by Dr. Robert Cohen dated April 26, 2006, which included information on an exercise study that was performed by Dr. Cohen in June of 2005. (TR 65-66) The Claimant was able to exercise for almost eleven minutes at that time. (TR 89) According to the results of that exercise study, the Claimant reached his anaerobic threshold. (TR 79) Dr. Repsher stated that this was significant because it meant that the Miner was not limited by lung capacity. (TR 79).

Dr. Repsher disagreed with some of the conclusions that Dr. Cohen drew from the exercise study. (TR 94-95) Dr. Cohen found that the Claimant had a significant gas exchange limitation to exercise. (TR 94) Dr. Repsher, in contrast, did not believe that the Claimant's gas exchange abnormalities limited his exercise "because his exercise wasn't limited [by his lungs]." (TR 95)

Dr. Repsher acknowledged that the results of several arterial blood gas studies were qualifying under the Department of Labor's standards for total disability. (TR 116) When asked how he could find that the Claimant was not totally disabled, given the qualifying arterial blood gas tests, Dr. Repsher stated that the qualifying arterial blood gas tests were enough to "establish

the presumption of total disability, but that this was a "rebuttable presumption." (TR 116-117) Dr. Repsher also stated that arterial blood gas studies were a "very crude and often inaccurate way of assessing a person's exercise capacity." (TR 69) Since the results of the exercise test, a much more sophisticated test, showed that the Claimant's ability to exercise or work was not limited by lung disease, the presumption established by the arterial blood gas tests was rebutted. (TR 122)

Pneumoconiosis and Total Disability

The Claimant's application for benefits was filed with the Department of Labor on June 15, 2001 and thus is governed by the permanent Regulations found in 20 C.F.R. § 718, which became effective on March 31, 1980. Under the new Regulations, the Claimant must establish the existence of pneumoconiosis, that he is totally disabled as a result of the disease, and that the disease arose from coal mine employment. Failure to establish any one of these elements precludes entitlement. Perry v. Director, OWCP, 9 B.L.R. 1-1, 1-2 (1986).

Pneumoconiosis

Section 718.202 provides that the existence of pneumoconiosis can be established by x-ray, autopsy or biopsy, or by the report of a physician exercising sound medical judgment stating the Claimant suffers from pneumoconiosis. 20 C.F.R. § 718.202 (2003).

X-Ray Reports:

Number	Date of X-Ray	Date of Report	Physician/ Qualifications[2]	Diagnosis
EX 7, EX 8[3]	4/28/89	5/2/89	Smith, ---	Non specific interstitial lung disease
EX 7, EX 8	10/8/94	10/8/94	Smith, ---	"
EX 7, EX 8	8/16/96	8/19/96	Kulwiec, ---	"
EX 7, EX 8, EX 9	6/26/97	6/26/97	Smith, ---	"
EX 7, EX 8, EX 9	7/10/97	7/10/97	Kulwiec, ---	Improving atelectasis and/or infiltrate
EX 7, EX 8	7/12/97	9/18/97	Smith, ---	Non specific interstitial lung disease

[2] The following abbreviations will be used in describing the qualifications of the physicians:
BCR – Board-certified radiologist;
B – B-reader;
A – A-reader; and
--- – Reader's qualifications unknown, not part of the record.

[3] The x-rays listed in EX 9, EX, 8, EX 7 and EX 6 are admissible as treatment records.

EX 7, EX 8	7/18/97	7/24/97	Nystrom, ---	Non specific interstitial lung disease
EX 7, EX 8	1/28/98	2/2/98	Kulwiec, ---	Right lower lobe infiltrate, emphysema
EX 6, EX 8	2/9/98	2/9/98	Smith, ---	Emphysema
EX 7, EX 6, EX 8	8/10/98	9/21/98	Kulwiec, ---	Emphysema
EX 7, EX 6, EX 8	8/25/00	8/28/00	Nystrom, ---	Non specific interstitial lung disease
EX 6[4]	9/7/01	9/7/01	Bechtel, ---	Subtle nodularity suggesting CWP
DX 16	4/4/02	4/4/02	Shockey	1/1
DX 20	4/4/02	7/24/02	Wiot, BCR, B	No CWP
CX 1	4/4/02	4/13/06	Cappiello, BCR, B	1/0
DX 23, EX 2	9/9/02	9/9/02	Repsher, B	0/0
DX 21	9/9/02	9/24/02	Wiot, BCR, B	No CWP
CX 7	9/9/02	5/4/06	Ahmed, BCR, B	1/1
CX 11	9/9/02	6/7/06	Cappiello, BCR, B	1/0
CX 2	6/14/05	4/13/06	Cappiello, BCR, B	1/0
EX 12	6/14/05	5/10/06	Wiot, BCR, B	No CWP
CX 3	3/22/06	4/13/06	Cappiello, BCR, B	1/0
EX 11	3/22/06	5/10/06	Wiot, BCR, B	No CWP

[4] This x-ray does not meet the standards adopted by the Regulations at 20 C.F.R. § 718.102 (2002). Thus, this x-ray cannot form the basis for a finding of the existence of clinical pneumoconiosis. See 20 C.F.R. § 718.202(a)(1)(2002).

According to the regulations concerning the development of evidence, "[t]he responsible operator designated pursuant to § 725.410 shall be entitled to obtain and submit, in support of its affirmative case, no more than two chest x-ray interpretations . . . ." 20 C.F.R. § 725.414(a)(3)(i) (2003). Similarly, "[t]he claimant shall be entitled to submit, in support of his affirmative case, no more than two chest x-ray interpretations." 20 C.F.R. § 725.414(a)(2)(i) (2003). The regulations further state that

> [t]he claimant shall be entitled to submit, in rebuttal of the case presented by the party opposing entitlement, no more than one physician's interpretation of each chest x-ray . . . submitted by the designated responsible operator or the fund, as appropriate, under paragraph (a)(3)(i) or (a)(3)(iii) of this section and by the Director pursuant to § 725.406.

20 C.F.R. § 725.414(a)(2)(ii) (2003). Similarly, for purposes of rebuttal, an employer is entitled to submit no more than one interpretation of each chest x-ray submitted by the claimant. 20 C.F.R. § 725.414(a)(3)(ii) (2003).

As part of his evidence, the Claimant submitted CX 10. (CX 10) This exhibit constitutes a letter from the Department of Health and Humans Services, dated January 1, 2001, to the Chief of the Division of Health concerning the results of an x-ray of the Claimant's chest. (CX 10) The results of this x-ray will not be considered, since the Claimant has already designated two x-ray interpretations in support of his affirmative case. Since the limitations set forth in 20 C.F.R. § 725.414 (2003) are mandatory and cannot be waived, CX 10 cannot be considered. Moreover, CX 10 fails to show the date the x-ray was taken, the date the x-ray was read by a doctor, the quality of the x-ray film, the name of the doctor who interpreted the x-ray, the qualifications of the doctor who interpreted the x-ray, or the type of opacities found. It therefore does not meet the standards for x-rays set forth in 20 C.F.R. §§ 718.202(a)(1); 718.102 (2002).

Where two or more x-ray reports are in conflict, the radiological qualifications of the physicians interpreting the x-rays must be considered. 20 C.F.R. § 718.202(a)(1) (2003). Readings by physicians who are both Board-certified radiologists and B-Readers are generally entitled to the greatest weight. Roberts v. Bethlehem Mines Corp., 8 BLR 1-211, 1-213 (1985); Sheckler v. Clinchfield Coal Co., 7 BLR 1-128, 1-132 (1984).

Concerning the x-ray evidence as a whole and the qualifications of the physicians, I find that I give greater weight to the interpretations of the B-readers over board-certified radiologists. Meadows v. Westmoreland Coal Co., 6 BLR 1-773, 1-776 (1984); Brown v. Bethlehem Steel Corp., 4 BLR 1-527, 1-530 (1981).

The x-ray evidence in this case is very close. Physicians who were either dually qualified or B-Readers read x-rays from late 2002 through early 2006 as being both positive and negative for pneumoconiosis.

Six of the above-mentioned x-ray reports found that the Claimant had pneumoconiosis. Five reports found no evidence of pneumoconiosis. However, the Board has held that an administrative law judge is not required to defer to the numerical superiority of x-ray evidence. Wilt v. Wolverine Mining Co., 14 B.L.R. 1-70, 1-76 (1990).

X-ray evidence may also be weighed based upon the qualifications of the physicians. First, an x-ray was taken by Dr. Shockey on April 4, 2002. Since Dr. Shockey is neither a certified B-reader nor a board certified radiologist, the undersigned gives substantially less weight to his opinion. (DX 16) This x-ray was interpreted by Dr. Wiot as being negative for pneumoconiosis and as having a profusion of 1/0 by Dr. Cappiello. (DX 20, CX 1) Both Dr. Wiot and Dr. Cappiello are board certified radiologists and B-Readers. However, after examining the curriculum vitaes of both physicians, it is clear that Dr. Wiot's credentials are superior to Dr. Cappiello's.

Dr. Cappiello has had experience as a resident in diagnostic radiology (1973-1976). His specialty is in diagnostic radiology, with a subspecialty in cardiac radiology.[5] (CX 11) However, Dr. Wiot has had much more experience in the field of radiology. Dr. Wiot was the Chairman for the Department of Radiology at the University of Cincinnati Medical Center (1984-1985), the Director of the Department of Radiology at the University of Cincinnati Hospital (1968-1992),[6] the Professor Emeritus of Radiology at the University of Cincinnati (1998-present),[7] a consulting radiologist at the Cincinnati Veterans' Administration Hospital (1962-present) and the Chief of Radiology at the Cincinnati Children's Hospital Medical Center (1973-1992). (DX 19) He has also held several positions on the American Board of Radiology throughout the past thirty years and he has held several positions with the American College of Radiology, including President from 1983-1984. (DX 19) He has also been a member of multiple professional societies involving radiology. (DX 19) He has authored or co-authored approximately fifty papers dealing with various aspects of diagnostic radiology. (DX 19) Moreover, much of Dr. Wiot's experience involves the area of pneumoconiosis. (DX 19)

Thus, although both Dr. Cappiello and Dr. Wiot are board certified radiologists and B-Readers, the undersigned finds Dr. Wiot to have vastly superior qualifications. His interpretation is thus given greater weight.

An x-ray dated September 9, 2002 was read as being negative for pneumoconiosis by Drs. Repsher and Wiot. (DX 23, DX 21) It was read as 1/1 by Dr. Ahmed and 1/0 by Dr. Cappiello. (CX 7, CX 11) For the reasons noted above, Dr. Wiot's interpretation is given greater weight than Dr. Cappiello's interpretation.

Dr. Ahmed is board certified in radiology. (CX 8) He is also a B-reader. (CX 8) He is currently the attending radiologist at Princeton Community Hospital in Princeton, WV. (CX 8) He was a resident in diagnostic radiology, an attending radiologist and an instructor in radiology

[5] This is the only information that can be determined from Dr. Cappiello's Curriculum Vitae. Dr. Cappiello submitted a two-page Curriculum Vitae, however it appears that the second page of this report is a piece of Dr. Ahmed's Curriculum Vitae, given that license numbers listed on the second page of Dr. Cappiello's Curriculum Vitae are the same license numbers that appear on the first page of Dr. Ahmed's Curriculum Vitae.

[6] He was also the Co-Director of the Department of Radiology at the Cincinnati General Hospital (1966-1967), the Associate Director of the Department of Radiology at the Cincinnati General Hospital (1963-1966) and the Assistant Director of the Department of Radiology at the Cincinnati General Hospital (1961-1963). (EX 1)

[7] He was also the Professor of Radiology at the University of Cincinnati (1966-1998), the Associate Professor of Radiology at the University of Cincinnati (1962-1966) and the Assistant Professor of Radiology at the University of Cincinnati (1959-1962). (EX 1)

at Mt. Sinai Medical Center. (CX 8) He is also a member of the American College of Radiology and the Radiological Society of North America. (CX 8) He has received substantial continuing medical education in the field of radiology. Dr. Repsher is a B-Reader. (DX 22) He had a fellowship in pulmonary and critical care medicine (1970-1972). (DX 22) He has an academic appointment as Associate Clinical Professor of Medicine Division of Pulmonary Sciences at the University of Colorado. (DX 22) He has written several journal articles and spoken at multiple symposiums on the topic of pulmonary medicine, including COPD. (DX 22)

As is noted above, readings by physicians who are both Board-certified radiologists and B-Readers are generally entitled to the greatest weight. Roberts v. Bethlehem Mines Corp., 8 BLR 1-211, 1-213 (1985). Thus, Dr. Ahmed's reading is entitled to greater weight than Dr. Repsher's reading.

X-rays dated June 14, 2005 and March 22, 2006 were also read by Drs. Cappiello and Wiot. For the reasons stated above, although both Dr. Cappiello and Dr. Wiot are board certified radiologists and B-Readers, the undersigned finds Dr. Wiot to have superior qualifications. His interpretation of each of these x-rays is thus given greater weight than Dr. Cappiello's interpretation of each of these x-rays.

In this case, the Claimant bears the burden of proof. After reviewing the qualifications of the physicians reading the reports, I find that the Claimant has not established the presence of pneumoconiosis pursuant to §718.202(a)(1).

Autopsy/Biopsy Reports:

No autopsy or biopsy reports are present in the record. Therefore, the Claimant has not established the presence of pneumoconiosis pursuant to § 718.202(a)(2).

Establishing Pneumoconiosis Pursuant to § 718.202(a)(3)

The presumptions described in §§ 718.304, 718.305 and 718.306 are not applicable. Therefore, the Claimant has not established the presence of pneumoconiosis pursuant to § 718.202(a)(3).

Medical Reports

Under § 718.202(a)(4), a determination of pneumoconiosis may also be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffered from pneumoconiosis as defined in § 718.201.

Medical reports should be well-reasoned and well-documented. Case law has established what a well-reasoned, well-documented medical report entails. A "documented" opinion is one that sets forth the clinical findings, observations, facts and other data on which the physician based the diagnosis. Fields v. Island Creek Coal Co., 10 B.L.R. 1-19, 1-22 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's history. See Hoffman v. B & G Construction Co., 8 B.L.R. 1-65, 1-66 (1985);

Hess v. Clinchfield Coal Co., 7 B.L.R. 1-295, 1-296 (1984). A "reasoned" opinion is one in which the administrative law judge finds the underlying documentation adequate to support the physician's conclusions. See Fields, 10 B.L.R. at 1-22.

Dr. Mark Shockey

On April 4, 2002, the Claimant was examined by Dr. Mark Shockey. (DX 11) The Claimant noted that, since May 1989, he had been employed by the Employer as a safety inspector and shift foreman. (DX 11) The Claimant also noted that, from 1962 until 1992, he smoked approximately one pack of cigarettes per day. (DX 11)

The Claimant told Dr. Shockey that he experienced a small amount of daily sputum, occasional coughing, and dyspnea. (DX 11) His dyspnea prevented him from walking more than one mile on level ground or climbing two flights of stairs without becoming winded. (DX 11)

Dr. Shockey's physical examination of the Claimant revealed rales and wheezes. (DX 11) A chest x-ray showed COPD and coal workers' pneumoconiosis. (DX 11, DX 16) The ventilatory study report revealed moderate obstruction. (DX 11, DX 15) The arterial blood gas study report revealed low blood gas values. (DX 11, DX 15)

Dr. Shockey concluded that the Claimant had coal workers' pneumoconiosis and COPD due to the Claimant's coal mine employment and history of smoking. (DX 11) Dr. Shockey believed that the COPD and the coal workers' pneumoconiosis caused mild impairment. (DX 11)

The undersigned finds Dr. Shockey's opinion, which is based upon physical examination, test results, x-ray reports, and the Claimant's work, social and medical histories, to be well-documented and well-reasoned.

Dr. Lawrence Repsher

Dr. Repsher examined the Claimant in September of 2002. (DX 23) The Claimant informed Dr. Repsher that he had worked as an underground coal miner for approximately thirty years. (DX 23) Most recently, he had been employed as an acting general mine foreman. (DX 23)

When asked about his smoking history, the Claimant stated that he smoked one pack per day for approximately thirty years. (DX 23) He had quit smoking between seven and ten years earlier. The Claimant noted that he had smoked a pipe transiently, but "never inhaled." (DX 23) The Claimant also told Dr. Repsher that he chewed tobacco. (DX 23)

The Claimant denied any respiratory symptoms, other than slowly progressive mild dyspnea on exertion. (DX 23) He denied any cough, chills, fevers, sweats or weight loss. (DX 23) A physical examination of the Claimant revealed nothing abnormal. (DX 23) Height was measured at seventy-two inches and weight was 239 pounds. (DX 23)

Dr. Repsher read the Claimant's x-ray as showing no evidence of coal workers' pneumoconiosis. (DX 23) Pulmonary function tests revealed "mild COPD without immediate bronchodilator response. Lung volumes were normal. The diffusing capacity is mildly reduced, consistent with mild emphysema." (DX 23) The arterial blood gas values were decreased. (DX 23)

Dr. Repsher concluded that there was "no evidence of coal workers' pneumoconiosis," that there was "mild COPD of no present clinical significance," that the Claimant had "moderate hypoxemia at rest, of no present clinical significance, since there is no evidence of even early cor pulmonale," and that there was "probable, mild, residual cigarette smoking habit." (DX 23) Dr. Repsher stated that, "as a result of the above, it is my opinion that [the Claimant] is not now and never has suffered from coal workers' pneumoconiosis or any other pulmonary or respiratory condition, either caused by or aggravated by his employment with Blue Mountain Energy Company as an underground coal miner." (DX 23)

Dr. Repsher based this opinion on multiple things. First, the Claimant had "no chest x-ray evidence of coal workers' pneumoconiosis." (DX 23) Second, the Claimant had "no pulmonary function test evidence of coal workers' pneumoconiosis. Coal workers' pneumoconiosis, when clinically significant, is primarily a restrictive disease. [The Claimant] has pure obstructive disease, which is a characteristic finding of cigarette smoking induced COPD and emphysema." (DX 23) Third, the Claimant's "symptoms of dyspnea on exertion are most likely due to his obesity and relatively sedentary life style." (DX 23)

The Claimant argues that Dr. Repsher's medical report must be completely discredited because of his statement that "[c]oal workers' pneumoconiosis, when clinically significant, is primarily a restrictive disease. [The Claimant] has pure obstructive disease, which is a characteristic finding of cigarette smoking induced COPD and emphysema." (DX 23) The Claimant believes that this statement goes against the position taken by the Department of Labor that the inhalation of coal mine dust can cause obstruction.

It is true that a physician's opinion cannot be given credit if it is hostile to the Act. See Wetherill v. Green Construction Co., 5 B.L.R. 1-248, 1-252 (1982). However, Dr. Repsher did not state that the inhalation of coal mine dust cannot cause obstruction. He stated that coal workers' pneumoconiosis is primarily a restrictive disease. He did not determine that coal workers' pneumoconiosis was only a restrictive disease. Thus, Dr. Repsher's opinion is not deemed to be hostile to the Act.[8] Therefore, Dr. Repsher's report will not be discredited.

Moreover, Dr. Repsher based his opinion that the Claimant did not have coal workers' pneumoconiosis or any respiratory condition caused by his coal mine work on more than simply his finding that coal workers' pneumoconiosis may be a restrictive disease. He also looked at x-ray evidence and based his findings on his physical examination of the Claimant and the

[8] See Stilner v. Island Creek Coal Co., 86 F.3d 337 (4th Cir. 1996)(holding that a physician's opinion should not be discredited merely because he states that the miner "likely" would have exhibited a restrictive impairment in addition to chronic obstructive pulmonary disease if he had coal workers' pneumoconiosis).

Claimant's work, social and medical histories. Therefore, Dr. Repsher's report will be given equal weight.

Dr. Joseph Renn

Dr. Renn was board certified in internal medicine and in pulmonary disease and was a B-reader of x-rays. (EX 10) Dr. Renn relied on treatment records, pulmonary function tests, arterial blood gas tests, medical reports from Drs. Shockey and Repsher, CT scans and x-ray reports when drafting his independent medical review of the Claimant. (EX 4) From the information contained in the above-mentioned sources, Dr. Renn was able to obtain an understanding of the Claimant's occupational history, the Claimant's history of tobacco use and the Claimant's past medical history. (EX 4)

After reviewing the above-mentioned information related to the Claimant's respiratory system, Dr. Renn determined that the Claimant had "very mild COPD owing to tobacco smoking" as well as a "very mild obstructive ventilatory defect." (EX 4). He also determined that "pneumoconiosis does not exist." (EX 4)

Dr. Renn stated that the Claimant was "a sixty-two year-old who … does not have pneumoconiosis." (EX 4) He concluded that

> it is with a reasonable degree of medical certainty that none of the above diagnoses were either caused, or contributed to, by his exposure to coal mine dust. It is with a reasonable degree of medical certainty that his very mild COPD is a result of his years of tobacco smoking rather than exposure to coal mine dust.

(EX 4)

Dr. Renn further concluded that, "when considering only his respiratory system, it is with a reasonable degree of medical certainty that he is not totally and permanently impaired to the extent that he would be unable to perform his last known coal mining job as safety inspector and shift foreman or any similar work effort." (EX 4).

In a deposition taken on June 1, 2006, Dr. Renn stated that his finding, that the Claimant's mild obstructive breathing impairment was not related to coal mine dust, was based on

> the fact that [the Claimant] had the pattern … that showed that his obstructive airway disease is a result of tobacco smoking; that being the fact that his FEF 25-75 is disproportionately reduced when compared with his peak expiratory flow rate and his FEV_1. That is the pattern of tobacco smoking. It is not the pattern of a person with medical coal workers' pneumoconiosis or coal mine dust-induced obstructive airway disease. Then, in 2002, he had a reduction of his diffusing capacity which was at that time by a percentage mildly reduced, but was normal when it was corrected for the alveolar volume. That, too, is a pattern consistent

with tobacco smoking but not consistent with a disease caused by coal workers' pneumoconiosis.[9]

(EX 10, pg. 6-7)

Further, on cross-examination, when the Claimant's counsel stated, "so, you found no medical coal workers' pneumoconiosis present here and you testified that was based on the absence of restriction on the pulmonary function test," Dr. Renn stated that his determination was also based on x-ray evidence and "the pattern of the dynamic ventilatory function in that [the Claimant] had obstructive airways disease, which could be consistent with coal workers' pneumoconiosis, but the pattern that he had is consistent with tobacco smoke-induced obstructive airways disease." (EX 10, pg. 50-51) Thus, Dr. Renn attributed all of the Claimant's obstruction to his smoking history. (EX 10, pg. 51)

When asked if the Claimant had any coal mine dust-related disease causing him impairment, Dr. Renn said "no." (EX 10, pg. 40) Dr. Renn stated that the exercise test in 2005 showed that there was no wasted ventilation and that fitness might be limited by heart disease. (EX 10) He testified that the Claimant's blood gas abnormality was not related to coal mine work as he would have associated diminished breathing reserve. (EX 10) The Claimant exercised to 5.9 mets which was beyond the required exertion level in the mines. (EX 10) The physician attributed the gas exchange abnormality to smoking rather than to mining. (EX 10).

The undersigned finds Dr. Renn's opinion, which is based upon treatment records, the Claimant's work, social and medical histories, and other physicians' medical reports, test results, and x-ray reports to be well-documented and well-reasoned.

Dr. Robert Cohen

In June of 2005, the Claimant was examined by Dr. Robert Cohen. (CX 5) The Claimant informed Dr. Cohen that his chief complaint was shortness of breath. (CX 5) The Claimant stated that his shortness of breath began five to seven years before, but had gotten worse in the preceding two years. (CX 5) The Claimant also complained of a cough, which started approximately five years before, but had gradually worsened. (CX 5) Further, he noted sputum production, which began two years before, but had also gradually worsened. (CX 5)

The Claimant also informed Dr. Cohen that he had been employed as an acting general foreman with Blue Mountain Energy from 2001 until 2004. (CX 5) He stated that he spent most of his time underground and that he had to do some hands-on work, including performing a complete examination of the mine. (CX 5) He told Dr. Cohen that he walked ten miles per day and often had to lift and carry objects weighing up to 100 pounds. (CX 5) He stated that he did not have any difficulty lifting items like logs, but that he experienced "difficulty moving them

[9] Dr. Renn bases this determination, in part, on the NIOSH publication entitled "The Criteria for Recommended Standard Occupational Exposure to Respirable Coal Mine Dust." (EX 10, pg. 53) Dr. Renn also cited to other publications in support of his conclusions. These publications were all admitted into the record as attachments to Dr. Renn's deposition.

from one place to another which was getting worse gradually." (CX 5) He noted that he wore a respirator mask between five and ten percent of the time. (CX 5)

The Claimant also told Dr. Cohen that he smoked an average of one pack of cigarettes per day between 1962 and 1996, excepting three years during the 1980s when he quit cigarettes and instead smoked, but did not inhale, a pipe 1-3 times per day. (CX 5) He smoked a pipe 1-3 times a day again between 1996 and 2000. (CX 5)

Dr. Cohen's physical examination of the Claimant revealed nothing abnormal. (CX 5) As part of his examination, Dr. Cohen took an x-ray of the Claimant and performed an arterial blood gas study and a pulmonary function study.[10]

Based upon his own examination of the Claimant, the results of the tests he performed on the Claimant, the Claimant's work, medical and smoking histories, and a review of multiple treatment records and prior medical reports, Dr. Cohen concluded that the Claimant had pneumoconiosis.[11] (CX 5)

The physician stated that he disagreed

> with Dr. Renn's and Dr. Repsher's opinions that [the Claimant] has very mild COPD due to smoking and not pneumoconiosis. He does have a mild obstructive impairment on spirometry, but severe diffusion impairment as well as severe gas exchange abnormalities with exercise. These impairments are caused by his exposure both to coal mine dust and to tobacco smoke. His $P0_2$ measured in the 50's is quite significant and means there is a significant loss in

[10] The results of this x-ray will not be considered, since the Claimant has already designated two other x-ray interpretations in support of his affirmative case. Since the limitations set forth in 20 C.F.R. § 725.414 (2003) are mandatory and cannot be waived, no x-ray reading by Dr. Cohen may be considered. The results of the blood gas study and the pulmonary function study, in contrast, may be considered, since the Claimant identified these studies by Dr. Cohen as part of his evidence on the Evidence Summary Form, and since the Claimant did not submit more blood gas or pulmonary function studies than the Regulations permit. Spirometry revealed a normal FVC and a mildly reduced FEV_1. (CX 5) Blood gases showed mild respiratory alkalosis. (CX 5) There was no significant response to bronchodilators. (CX 5) An exercise tolerance test went for about eleven minutes and was stopped due to leg fatigue and dyspnea. (CX 5)

[11] Dr. Cohen based his opinion that the Claimant had pneumoconiosis on multiple factors, including x-ray evidence. This included Dr. Cohen's reading as well as a September 9, 2002 reading by Dr. Wiot finding no pneumoconiosis, an April 4, 2002 reading by Dr. Shockey, who Dr. Cohen noted was not a B-Reader nor a board certified radiologist, finding a 1/1 profusion of opacities, an April 4, 2002 reading by Dr. Wiot finding no pneumoconiosis, a September 7, 2001 reading by Dr. Bechtel noting subtle nodularity suggesting coal workers' pneumoconiosis, and a letter dated January 2, 2001 stating that the Claimant had coal workers' pneumoconiosis. (CX 5)

As is noted above, the x-ray reading by Dr. Cohen and the January 2, 2001 letter are inadmissible. Given the remaining x-ray evidence available to Dr. Cohen, it seems unlikely that a finding of clinical pneumoconiosis could be maintained. However, Dr. Cohen stated in his opinion that a lack of positive x-ray reports "would not change [his] opinion that [the Claimant] has substantial historical and physiological evidence of coal workers' pneumoconiosis related to coal dust exposure." (CX 5) Moreover, Dr. Cohen's finding of legal pneumoconiosis was based on a vast array of information besides the x-ray evidence, including the Claimant's thirty year history of coal mine employment, physical symptoms consistent with chronic lung disease, the results of the pulmonary function and cardiopulmonary exercise testing and the lack of exposure to other occupational hazards that would explain his physical problems. Thus, Dr. Cohen's opinion that the Claimant has legal pneumoconiosis is well-documented and well-reasoned and will therefore receive equal weight.

> [the Miner's] ability to transfer oxygen to exercising tissues. I disagree with Dr. Repsher's opinion that [the Miner's] hypoxemia is of no clinical significance and that his symptoms of dyspnea are explained by obesity and relatively sedentary life style. He has a clearly abnormal ventilatory limit to exercise and abnormal gas exchange. This is not due to obesity. People may be dyspneic due to obesity, but they would not have the objective findings of diffusion impairment and gas exchange with exercise that [the Claimant] has.

(CX 5).

Dr. John Parker

Dr. Parker reviewed treatment records, medical reports and the Claimant's social, work and medical records. (CX 6) In April of 2006, Dr. Parker drafted a report based upon his review of the above-mentioned information. (CX 6) The physician stated that

> [i]n view of the above medical records and employment history it is my medical opinion that [the Claimant] suffers from pneumoconiosis, manifested as a[n] obstructive lung disease, with an FEV_1 revealing mild but gradually progressing reductions.[12] His FEV_1/FVC ratio has also overall become progressively reduced over time, making it clear that he has an obstructive impairment. His two most recent PFTs show very little improvement with bronchodilators, making it clear that asthma is not the source of his obstruction. His lung volumes show that restrictive disease does not account for his impairment. As has been seen in significant subsets of coal miners, [the Claimant's] arterial blood gas studies reveal a substantial impairment, beyond what is seen on the spirometry. The recent cardiopulmonary study is very strong evidence for a significant functional impairment due to chronic respiratory disease. [The Claimant] also has a quite severely reduced diffusing capacity, which further

[12] Dr. Parker based his opinion that the Claimant had pneumoconiosis on multiple factors, including x-ray evidence. (CX 6) This included Dr. Cohen's x-ray reading as well as a September 9, 2002 reading by Dr. Wiot finding no pneumoconiosis, an April 4, 2002 reading by Dr. Shockey finding a 1/1 profusion of opacities, an April 4, 2002 reading by Dr. Wiot finding no pneumoconiosis, a September 7, 2001 reading by Dr. Bechtel noting subtle nodularity suggesting coal workers' pneumoconiosis, and a letter dated January 2, 2001 stating that the Claimant had coal workers' pneumoconiosis. (CX 6)

As is noted above, the x-ray reading by Dr. Cohen and the January 2, 2001 letter are inadmissible. Given the remaining x-ray evidence available to Dr. Parker, it seems unlikely that a finding of clinical pneumoconiosis could be maintained.

However, it does not appear that Dr. Parker ever even made a finding of clinical pneumoconiosis. He stated that "[i]n rendering this opinion, I am aware that a number of x-ray interpretations have been reported to be negative for the classical lesion of coal workers' pneumoconiosis….[However,] the epidemiological evidence for a causal link between coal dust and COPD (even in the absence of chest x-ray evidence for opacities consistent with CWP) is massive and irrefutable." (CX 6)

Further, Dr. Parker's finding of legal pneumoconiosis is based upon multiple factors other than the x-ray reports, including medical reports, test results, and the Claimant's social, work and medical histories.

Thus, Dr. Parker's report is considered to be well-documented and well-reasoned and will therefore receive equal weight.

> confirms the substantial nature of his impairment and progressively worsening hypoxemia, with normal lung volumes. [The Claimant's] COPD with moderately severe hypoxemia and diffusing impairment is caused in substantial part by both his 30 years of coal mine employment, ending in 2004 and by his approximately 30 pack year smoking history ending around 1996…. Concerning the opinions of Dr. Renn and Dr. Repsher, attributing [the Claimant's] COPD solely to smoking, I cannot agree in view of the epidemiological evidence, the particular history of [the Claimant's] coal mine work and smoking, and the clinical evidence and progression, as discussed above. I also disagree with their opinions that [the Claimant] is not disabled.

(CX 6) Dr. Parker then stated,

> [i]n my opinion, [the Claimant's] respiratory disorder is substantially due to his occupational exposure to coalmine dust and clearly not only the result of tobacco smoke. In addition, his respiratory impairment would prevent the performance of his last coalmine job. I also note that in fact [the Claimant] had a complete cardiopulmonary exercise test, which revealed significant gas exchange limitation due to exercise, which was clearly due to his pneumoconiosis. This is the best evidence we have for his inability to do physically demanding work.

(CX 6).

Dr. Parker's report is considered to be well-documented and well-reasoned.

Supplemental Reports

On July 10, 2006, Dr. Cohen reviewed the hearing transcript and Dr. Renn's deposition. (CX 13) Dr. Cohen disagreed with Dr. Renn's determination that the Claimant's FEF 25-75 rules out coal dust exposure as a cause of lung disease. (CX 13) Dr. Cohen further disagreed with Dr. Renn's finding that the Claimant's pattern of diffusion impairment rules out coal mine dust exposure as a cause of the Claimant's lung disease. (CX 13) Dr. Cohen stated that

> It remains my opinion, even after reviewing the deposition and hearing testimony discussed above, and the comments made by Drs. Renn and Repsher, that the sum of the medical evidence in conjunction with this patient's work history still indicate that the miner's 30 years of coal mine dust exposure as well as his 30 pack years of exposure to tobacco smoke were significantly contributory to the development of his mild obstructive lung disease, diffusion impairment, and gas exchange abnormalities on arterial blood gases. This degree of impairment is clearly disabling for the heavy labor of his last coal mining job as an acting general foreman.

(CX 13).

On July 31, 2006, Dr. Renn noted that he had reviewed the Claimant's testimony detailing his job duties. (EX 13) He stated that his review of these duties did not change his opinion that the Claimant was able to perform his previous job. [13] (EX 13) On September 18, 2006, Dr. Renn responded to Dr. Cohen's July 2006 report. (EX 14) Dr. Renn stated that "Dr. Cohen has mischaracterized my deposition testimony. My opinion is that the FEF 25-75 is disproportionately reduced in those individuals in whom it has been affected by tobacco smoke whereas in those in whom it has been affected by coal mine dust exposure or the development of coal workers' pneumoconiosis it is proportionately reduced." (EX 14) Further, concerning whether the Claimant's pattern of diffusion impairment rules out coal mine dust exposure as a cause of lung disease, Dr. Renn stated,

> Dr. Cohen has stated that the D1/Va 'does not add much useful information.' Johnson addressed the question of the validity of the DLCP and the D1/Va. He evaluated 2,313 patients. There were subgroups of patients with asthma, emphysema, extrapulmonary lung disease, interstitial lung disease and lung resection. He stated, 'unadjusted DLCO and KCO percent predicted values showed large differences and much variability, so can be misleading. As expected, KCO and DLCO were nearly identical.' That is the D1/Va. He further stated, 'Adjusting predicted DLCO and KCO for alveolar volume provides a better assessment of lung function.' Thusly is Dr. Cohen's contention effectively controverted. In response to his comments regarding the levels of diffusion impairment in coal miners, I believe my deposition testimony and the scientific articles themselves attest strongly to the validity of my statements. It speaks volumes that Dr. Cohen remained silent in regard to several of the scientific articles. He mentioned the paucity of subjects in the 1982 article. However, he did not mention that 511 coal workers were studied by Wang and Christiani, including those having chest radiographs in stages 0 through category 3. I view his failure to reply to all of the findings published in the scientific treatises to which I referred as denoting his inability to refute them with scientific literature of equal standing.

(EX 14)

Dr. Renn also stated,

> …It remains my opinion, even after reviewing Dr. Cohen's Second Supplemental Consulting Medical Opinion, that [the Claimant] does not have a coal mine dust-related disease that is causing him impairment. Further, he does not have a totally-impairing either pulmonary or respiratory impairment from any cause.

(EX 14).

[13] Based on this supplemental report, the undersigned finds that Dr. Renn had a complete picture of the Claimant's work history and previous job duties.

Dr. Cohen responded to Dr. Renn's September 2006 remarks on October 19, 2006. Dr. Cohen stated,

> Dr. Renn seems to think he can distinguish coal dust induced impairment from tobacco smoke induced impairment based on the reduction in the FEF 25-75. There is no basis whatsoever for this argument in the medical literature. The FEF 25-75 is not a good indicator of "small airways disease" and is only used as an indicator of early airway obstruction.

(CX 14) Dr. Cohen then stated that the pattern of diffusion impairment did not rule out coal mine dust exposure as a cause of the Claimant's lung disease. Dr. Cohen stated,

> Dr. Renn continues to support his opinion that the D1/Va is a useful measurement for distinguishing patterns of lung disease and cites an article published in the year 2000 which "effectively controverted" my opinion. The fact remains, regardless of what Dr. Renn thinks, the D1/Va does not give us much useful information and certainly cannot be used to determine whether or not coal mine dust is a cause of diffusion impairment. Not only does the AMA guides not even list the D1/Va in their tables, but the most recent American Thoracic Society and European Thoracic Society joint statement, published in 2005 after an extensive review of the literature also does not recommend giving this measurement any significant interpretive value.

(CX 14)

> Finally, Dr. Cohen determined that
>
> [i]t remains my opinion, even after reviewing the additional comments made by Dr. Renn, that the sum of the medical evidence in conjunction with this patient's work history still indicate that the miner's 30 years of coal mine dust exposure as well as his 30 pack years of exposure to tobacco smoke were significantly contributory to the development of his mild obstructive lung disease, diffusion impairment, and gas exchange abnormalities on arterial blood gases. This degree of impairment is clearly disabling for the heavy labor of his last coal mining job as an acting general foreman.

(CX 14).

Both the Employer and the Claimant submitted the above-listed supplemental reports as evidence in this trial. These reports were sent to the undersigned as either rebuttal evidence or rehabilitative evidence. The Regulations state that rebuttal evidence may consist of "no more than one physician's interpretation of each chest x-ray, pulmonary function test, blood gas study, autopsy or biopsy" that has been submitted by the opposing party. 20 C.F.R. §§ 725.414(a)(2)(ii); 725.414(a)(3)(ii) (2003).

When a party's rebuttal evidence tends to undermine the conclusion of a physician who prepared a medical report for the opposing party, that physician is entitled to submit an additional statement explaining his conclusion in light of the rebuttal evidence. 20 C.F.R. §§ 725.414(a)(2)(ii); 725.414(a)(3)(ii) (2003).

The evidence submitted by the parties in this case, which consisted of reports by Dr. Cohen reiterating why he believed that the Claimant did suffer from clinical and legal pneumoconiosis that was totally disabling and reports by Dr. Renn reiterating why he did not believe that the Claimant suffered from clinical or legal pneumoconiosis that was totally disabling, cannot properly be considered to be rebuttal or rehabilitative evidence. These reports do not meet the requirements for rebuttal or rehabilitative evidence set forth in 20 C.F.R. §§ 725.414(a)(2)(ii); 725.414(a)(3)(ii) (2003).

These reports are admissible, however, as supplemental opinions. See Stamper v. Westerman Coal Co., BRB No. 05-0946 BLA (July 26, 2006) (unpub.)(upholding the ALJ's finding that Dr. Baker's October 2000 report was a "supplemental opinion, in that it simply expounds on Dr. Baker's May 29, 1997 examination and report…." Id.).

The undersigned finds all of these supplemental reports to be well-documented and well-reasoned.

CT Scans

The Board has determined that CT scan evidence should be weighed separately from the chest x-rays. Melnick v. Consolidation Coal Co., 16 B.L.R. 1-31 (1991)(en banc).

In the present case, the Employer submitted Dr. Jerome Wiot's interpretation of a CT scan dated February 9, 1998. (EX 1) Dr. Wiot determined the films were of an acceptable quality by ILO standards. (EX 1) He further stated that the CT scan showed "no evidence of coal workers' pneumoconiosis. There are a few small nondescript nodules noted and a patchy area of air space disease in the superior segment of the right lower lobe. This is not a manifestation of coal dust exposure." (EX 1) [14]

The CT scan evidence fails to establish that the Claimant suffers from coal workers' pneumoconiosis.

Treatment Records

In Dempsey v. Sewell Coal Co., 23 B.L.R. 1-47 (2004) (en banc), the Board held that treatment records, containing multiple pulmonary function and blood gas studies that exceed the limitations at § 725.414, are properly admitted. This is so regardless of whether the records are offered by a claimant or an employer.

[14] Other CT scans which were taken in the course of the Claimant's general medical treatment are also included in the record as treatment records. These CT scans do not discuss the presence or absence of pneumoconiosis.

In the present case, treatment records were submitted into evidence. In February 1998, at St. Mary's Hospital, the Claimant underwent a fiberoptic bronchoscopy. The diagnosis was "improving hemoptysis and resolving infiltrate, possibly due to bronchitis or pneumonitis." (EX 9)

In September 2000, the Miner was evaluated at the Rangely Family Medicine Encounter. Complaints included shortness of breath on walking. (EX 8) Spirometry revealed a 15% improvement after bronchodilator therapy. (EX 8) Impressions were chronic obstructive pulmonary disease with reversibility and fatigue. (EX 8).

In September 2001, the Claimant reported dyspnea on climbing a grade to Dr. Bechtel. (EX 6) Spirometry in September 2000 had shown moderate lung disease with a significant response to bronchodilators. (EX 6) Examination was negative except for a little wheeze on the right and a small amount of sputum production. (EX 6)

Conclusion

Based upon all of the afore-mentioned evidence, the undersigned must now determine whether the Claimant has established, through medical reports, that he has pneumoconiosis.

As is noted above, under § 718.202(a)(4), a determination of pneumoconiosis may be made if a physician, exercising sound medical judgment finds that the miner suffered from pneumoconiosis as defined in § 718.201.

Pneumoconiosis is defined as "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or clinical, pneumoconiosis and statutory, or legal, pneumoconiosis." 20 C.F.R. § 718.201 (2003).

Clinical pneumoconiosis is defined as "those diseases recognized by the medical community as pneumoconiosis, i.e. the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment." 20 C.F.R. § 718.201 (2003). This includes, "but is not limited to, coal workers' pneumoconiosis." Id.

Dr. Shockey concluded that the Claimant had coal worker's pneumoconiosis, based on x-ray evidence. (DX 11) Dr. Repsher determined, based on his examination of the x-rays, that the Claimant had no evidence of coal workers' pneumoconiosis. (DX 23) Dr. Renn also determined, with a reasonable degree of medical certainty, that the Claimant did not have pneumoconiosis. (EX 4) Dr. Cohen found that the Claimant had pneumoconiosis. (CX 5) However, as is noted above, Dr. Cohen relied upon inadmissible x-rays when making this determination. Given the x-ray evidence available to Dr. Cohen after discounting the inadmissible reports, it seems unlikely that a finding of clinical pneumoconiosis could be maintained. It appears that Dr. Parker only made a finding of legal pneumoconiosis. (CX 6) However, even if Dr. Parker had made a finding of clinical pneumoconiosis, he, like Dr. Cohen,

relied upon inadmissible x-ray reports. Thus, a finding of clinical pneumoconiosis could not be maintained by Dr. Parker either.

The medical reports in this case do not establish the existence of clinical pneumoconiosis.

Legal pneumoconiosis includes "any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment." 20 C.F.R. § 718.201 (2003)(emphasis added).

There is clearly a difference of opinion among well-qualified physicians who have given detailed statements in this case concerning whether the Claimant has legal pneumoconiosis.

Dr. Shockey concluded that the Claimant had COPD due to the Claimant's coal mine employment and history of smoking. (DX 11)

Dr. Repsher found "mild COPD of no present clinical significance." (DX 23) He concluded that the Claimant has never suffered from any pulmonary or respiratory condition, either caused by, or aggravated by, his employment with Blue Mountain Energy. (DX 23)

Dr. Renn determined that the Claimant had very mild COPD due to his history of smoking, as well as a very mild obstructive ventilatory defect. (EX 4). He stated, with a reasonable degree of medical certainty, that the Claimant did not have pneumoconiosis. (EX 4) He also noted that, while pneumoconiosis can manifest itself as obstructive airway disease, the Claimant's pattern of obstruction proved that the Claimant's obstructive airway disease was due to tobacco smoking. (EX 4) Dr. Renn offered extensive research to support this opinion. (EX 10, EX 14) He cited to multiple articles from medical journals such as the American Journal of Industrial Medicine and the British Journal of Occupational and Environmental Medicine. (EX 10) His opinion is considered to be well-reasoned and well-supported.

Dr. Cohen disagreed with Dr. Renn's and Dr. Repsher's opinions that Claimant's very mild COPD was due to smoking and not pneumoconiosis. (CX 5) He concluded that the Claimant had mild obstructive impairment on spirometry and severe diffusion impairment as well as severe gas exchange abnormalities with exercise. (CX 5) He believed that these impairments were caused by his exposure both to coal mine dust and tobacco smoke. (CX 5) Dr. Cohen's disagreement with Dr. Renn's conclusion that the Claimant's pattern of obstruction proved that the Claimant's obstructive airway disease was due to tobacco smoking was also well supported. He, too, cited to multiple studies and articles from medical journals. (CX 13, CX 14)

Dr. Parker stated that it was his opinion that the Claimant suffered from pneumoconiosis, manifested as an obstructive lung disease, which was caused by both his coal mine employment and his smoking history. (CX 6)

All of the physicians are extremely qualified to discuss the Claimant's pulmonary problems. Except for Dr. Shockey, who did not provide an extensive curriculum vitae,[15] all have had significant experience with internal and pulmonary medicine, including the publication of articles in this field, professional appointments in the field of pulmonary medicine and teaching positions at local universities. Further, all of their reports are well-reasoned and well-documented. Moreover, despite the fact that Drs. Renn and Cohen disagree as to the meaning of some of the Claimant's test results, their findings and reports are each well-supported.

The undersigned finds that these reports are evenly balanced, and should receive equal weight. As is noted above, the Claimant bears the burden of establishing the presence of pneumoconiosis by a preponderance of the evidence. The Claimant has not proven that he has legal pneumoconiosis.

Since the Claimant has not established the presence of either clinical or legal pneumoconiosis, the criteria of §718.202(a)(4) has not been met.

Entitlement

The Claimant failed to prove the existence of pneumoconiosis by x-ray, autopsy or biopsy, or by the report of a physician exercising sound medical judgment stating the Claimant suffers from pneumoconiosis. Since proving the existence of pneumoconiosis is necessary in order for the Claimant to receive benefits, his claim must be denied. The Claimant is not entitled to benefits under the Act.

Attorney's Fees

The award of an attorney's fee under the Act is permitted only in cases in which the Claimant is found to be entitled to the receipt of benefits. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for representation services rendered to him in pursuit of his claim.

ORDER

The claim of T. G. for benefits under the Act is hereby **DENIED**.

A

RICHARD K. MALAMPHY
Administrative Law Judge

RKM/KBE/jcb

[15] It is noted, however, that Dr. Shockey is board certified in internal medicine and is designated a diplomate certified in the subspecialty of pulmonary disease.

Newport News, Virginia

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.478 and 725.479. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).